BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **KENNETH BISTRICKY, M.D.** Holder of License No. 8807 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-04-0521A **CONSENT AGREEMENT FOR LETTER OF REPRIMAND**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Kenneth Bistricky, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver,

express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

Kenneth Bistricky MD
KENNETH BISTRICKY, M.D.

DATED: 8 August '06

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 8807 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-04-0521A after receiving a complaint regarding Respondent's care and treatment of inmates at the Arizona Department of Corrections (ADOC).

4. Respondent, a Dermatologist by training, was hired by ADOC in 1999 as a Dermatologist and Primary Care Physician.

5. A Board Medical Consultant reviewed the records of the patients in question and found quality of care issues with three patients.

PATIENT MC

6. MC, a sixty year-old male, presented to Respondent with a history of an Aortic Valve Replacement (AVR) and single vessel coronary artery bypass graft. Respondent placed MC on Coumadin to prevent systemic embolic events. Respondent monitored MC between February 7, 2003 and April 29, 2003. During this period MC's Internal Normalized Ratios (INR) were measured on several occasions, however, Respondent only recorded MC's INR once in the first month of follow-up.

7. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of

treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because they only included one INR measure in the period Respondent treated MC.

8. On February 20, 2003 Respondent reported a subtherapeutic INR of 1.2. An INR of 2.0 – 3.0 is considered effective. Respondent did not increase MC's Coumadin dose based on the low INR level. On February 25, 2003 another physician (Physician) noted the low INR and changed MC's Coumadin dose to 3 mg. Respondent did not adjust MC's Coumadin dosage until Physician suggested a therapeutic INR goal of 2.5 – 3.0.

9. On February 27, 2003 Respondent noted the INR tests performed by Physician on February 4, 2003, February 5, 2003, and February 8, 2003 decreased from 2.3 to 1.3, indicating MC had been subtherapeutic since February 8, 2003. Respondent did not increase MC's Coumadin dose. Instead, Respondent questioned MC's compliance with the Coumadin and requested MC come in for follow-up.

10. The standard of care requires Respondent to monitor an AVR patient who has started receiving Coumadin therapy every few days until a stable dose response has been achieved to prevent systemic embolic events. If INR value is not within the normal range the physician should intervene to obtain normal range.

11. Respondent deviated from the standard of care because he failed to monitor MC every few days to assure a stable dose response was achieved. Respondent failed to intervene when MC's INR of February 20, 2003 was 1.2, far below the normal range.

12. MC was subject to potential harm because sub-therapeutic INRs in a patient with AVR increase risk of blood clot formation in and around the heart valve with subsequent emboli.

PATIENT EH

13. On January 27, 2004 EH, a forty-six year-old male, presented to Respondent for evaluation of thumb injury, a history of Hepatitis C, moderate to severe epistaxis episodes over a four to six week period and symptomatic anemia. EH was seen several times urgently by the on duty nurse (Nurse) from January 2004 to March 2004 for continuous severe epistaxis and was treated symptomatically without long term relief. EH's treatment included packing EH's nose with cotton balls soaked with lidocaine and epi, observation for sixty minutes and ordering a complete blood count (CBC) and chemistry panel (Chem Panel).

14. On February 17, 2004 Respondent saw EH and noted he had a history of severe epistaxis, was anemic and had low iron levels. Respondent ordered a CBC and Chem Panel and scheduled a follow-up visit. Respondent did not do orthostatics or further question the hemodynamics. On February 23, 2004 Respondent noted EH's follow-up lab results revealed a low iron level and hemoglobin (Hgb) of 8.9. Respondent asked about other sites of possible bleeding, but did not recognize the anemia could be related to EH's recurrent and undiagnosed epistaxis. Respondent placed EH on iron supplements and ordered a CBC and Chem Panel to be completed in eleven weeks with a follow-up visit in thirteen weeks.

15. On March 11, 2004 EH presented to Nurse for his follow-up visit and complained of feeling very tired. Nurse noted EH's skin and mucous membranes were pale. The physician on duty ordered a CBC with stat results and scheduled a follow-up for the next day. On March 12, 2004 he found EH to be orthostatic and referred him to the hospital because the prison ear, nose, and throat physician was unavailable.

16. The standard of care for diagnosis and treatment of epistaxis requires the physician to evaluate the patient's hemodynamic status and, if low pressure is noted, to

check orthostatic blood pressures/pulses. The standard of care for successful management requires the physician to identify the site of bleeding and whether it is anterior or posterior bleeding. The standard of care requires the physician to order appropriate labs based on the evaluations of patient's history and physical examination information and recognize that epistaxis can be urgent and emergent and can lead to hemodynamic compromise.

17. Respondent deviated from the standard of care because he failed to do orthostatics or any further hemodynamic testing even though EH had a history of severe epistaxis and a low blood pressure. Although Respondent appropriately asked about other sites of possible bleeding, Respondent deviated from the standard of care because he failed to recognize that the anemia could be related to EH's recurrent and undiagnosed epistaxis and failed to recognize whether the bleeding was anterior or posterior so that the bleeding could be successfully managed. Respondent deviated from the standard of care because he failed to evaluate EH's history and physical examination information and recognize that epistaxis was urgent and emergent because Respondent did not plan a follow-up until three months later, despite the Hgb being 8.9.

18. EH was harmed because he became anemic and hemodynamically unstable secondary to recurrent epistaxis.

PATIENT DB

19. On October 21, 2003 DB, a sixty-five year-old male, presented to Respondent with a history of hypertension, cerebrovascular accident and renal insufficiency. DB was taking Hydrochlorothiazide and Enalapril for high blood pressure. Respondent ordered a CBC, urinanalysis and prostate specific antigen labs for February 2004 and scheduled a follow-up in six months.

20. On December 9, 2003 Respondent noted DB developed hyperkalemia and had a urinary tract infection. Respondent started DB on Bactrim DS. DB's potassium level was 6.2. Respondent did not consider the effects of Enalapril on DB's potassium level or order an EKG to determine if there were any clinical effects from DB's elevated potassium level. Respondent sent for repeat labs, but they were not performed.

21. Another physician ordered labs and an EKG. The lab report dated February 27, 2004 showed an even higher potassium level of 6.9. However, Respondent never saw these results because he was not working that day. Based on the lab and EKG reports DB was transferred to the hospital for further evaluation and management.

22. The standard of care for hyperkalemia requires the physician consider the medications the patient is taking, consider the differential diagnosis for hyperkalemia and order an EKG to evaluate the clinical effects that are primarily seen in the EKG. The standard of care requires a physician to review a spurious repeat potassium the same day or the next day as acute elevations of potassium may show characteristic EKG changes.

23. Respondent deviated from the standard of care because he failed to consider that, due to DB's renal insufficiency, the Enalapril could have caused the increase in potassium levels. Respondent failed to order an EKG to evaluate the clinical effects of an elevated potassium level. Additionally, Respondent deviated from the standard of care by failing to ensure a repeat potassium level was measured following the elevated potassium level he noted on December 9, 2003.

24. DB was subject to potential harm because Respondent's failure to address the abnormal lab could have been life threatening.

25. DB was harmed because he developed hyperkalemia and renal insufficiency requiring hospitalization and medication changes.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient.")

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.")

4. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.")

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for general mismanagement of three patients resulting in potential and actual harm to the patients.

2. This Order is the final disposition of case number MD-04-0521A.

DATED AND EFFECTIVE this 12th day of October, 2006.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
TIMOTHY C.MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13th day of October, 2006 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 13th day of October, 2006 to:

Kenneth Bistricky, M.D.
Address of Record

Investigational Review